C. L. "BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Ekfer Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

June 10, 2010

Joseph Caroselli Idaho Elks Rehabilitation Hospital Po Box 1100 Boise, ID 83702

FILE COPY

Provider #133025

Dear Mr. Caroselli:

On May 7, 2010, a complaint survey was conducted at Idaho Elks Rehabilitation Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004598

Allegation #1: A patient received long physical therapy sessions that left her hurting and upset.

Findings #1: An unannounced survey of the hospital was conducted 5/05/10 through 5/07/10. During the course of the investigation 10 medical records were reviewed. Staff members and 5 current patients were interviewed.

One female patient was admitted to the hospital for rehabilitation after a left total hip arthroplasty on 3/04/10. The admitting History and Physical documented the patient suffered an intraoperative fracture of the trochanter (the bony prominence at the top of the femur near the hip). The admitting physician documented this fracture complicated rehabilitation in that the patient was restricted to toe touch weight bearing precautions, in addition to routine hip precautions instituted after hip surgeries. The physician indicated the patient required acute inpatient rehabilitation for a number of reasons, including the need for an intense level of physical and occupational therapy.

Physical therapy notes revealed that the patient received physical therapy twice a day, one session was approximately 60 minutes and another session was 30 minutes. There was documentation that the patient had difficulty with the weight bearing precautions for the left hip. Improvement with adhering to this precaution was noted throughout the course of treatment.

Documentation from four therapy sessions revealed the patient complained of pain. However it was documented the pain was tolerable and medication (or other intervention) was provided to the patient. Review of physician progress notes and nursing documentation indicated pain was addressed and managed. There was no indication of dissatisfaction or concern with therapy services reported to the physicians providing care.

During an interview, a physical therapy assistant stated some of the first questions asked to patients were regarding pain. For example, were they experiencing pain, what level was the pain, and would they like pain medication prior to starting therapy?

The patient's Social Worker was interviewed. She stated that she recalled the family conference, held on 3/12/10, with the family, the physical therapy assistant, the occupational therapist, and the patient's head nurse. She stated there was nothing mentioned during the family conference regarding the patient's, or the family's, displeasure with services provided.

An LPN who worked with the patient during her hospital stay was interviewed. She stated the patient did not express concerns related to therapy services while the patient was treated at the hospital.

The Physical Therapy Site Manager was interviewed. He stated he reviewed the medical record and confirmed the therapy sessions did not indicate anything unusual in regards to the length or regimen of the sessions.

The Director of Rehab Services was interviewed. She stated she reviewed the medical record and interviewed staff members who cared for the patient. She stated the medical record indicated the patient received appropriate pain management interventions with positive results. She stated during her investigation there was no indication that the patient received extraordinary therapy services or that the patient was dissatisfied with the therapy services provided.

The patient's primary physical therapy assistant was interviewed. She stated she was not aware of the patient's feelings or concerns regarding the therapy provided.

During the survey, four medical records of patients who had been discharged and six current medical records were reviewed. Three of these medical records (two closed and one current) were for patients treated by the same physical therapy assistant as the record above. Medical record review revealed a similarly intense therapy regimens as described above.

Five current patients were interviewed, including one who was treated by the same physical therapy assistant. All patients stated they were satisfied with the care they received and the regard with which they were treated.

It could not be verified that patients received long physical therapy sessions that left them hurting and upset.

Conclusions: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: A patient was yelled at and treated in an intimidating manner by a physical therapy assistant.

Findings #2: One medical record revealed an elderly patient was admitted to the hospital for rehabilitation after a left total hip arthroplasty on 3/04/10. The admitting History and Physical documented the patient suffered an intraoperative fracture of the trochanter (the bony prominence at the top of the femur near the hip). The admitting physician documented this fracture complicated rehabilitation in that the patient was restricted to toe touch weight bearing precautions, in addition to routine hip precautions instituted after hip surgeries. The physician indicated the patient required acute inpatient rehabilitation for a number of reasons, which included the need for an intense level of physical and occupational therapy.

There was no indication in the medical record that the patient had concerns with the physical therapy assistant.

The patient's Social Worker was interviewed. She stated that she recalled the family conference, held on 3/12/10, with the family, the physical therapy assistant, the occupational therapist, and the patient's head nurse. She stated there was nothing mentioned during the family conference regarding the patient's, or the family's, displeasure with the physical therapy assistant.

An LPN who worked with the patient during her hospital stay was interviewed. She stated the patient did not express concerns related to therapy services while the patient was treated at the hospital.

The patient's primary physical therapy assistant was interviewed. She stated she was not aware of the patient's perceptions toward her or the patient's concerns regarding the therapy provided.

During the survey, four medical records of patients who had been discharged and six current medical records were reviewed. Three of these medical records (two closed and one current) were for patients treated by the same physical therapy assistant as the record above. No documentation was found to indicate patients had been treated in an intimidating manner.

Five current patients were interviewed, including one who was treated by the same physical therapy assistant. All patients stated they were satisfied with the care they received and the regard with which they were treated.

Joseph Caroselli June 10, 2010 Page 4 of 5

It could not be verified that a patient was treated in an intimidating manner by a physical therapy assistant.

Conclusions: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: A fracture sustained during surgery worsened as a result of a patient's treatment at the hospital.

Findings #3: One female patient was admitted to the hospital for rehabilitation after a left total hip arthroplasty on 3/04/10. The admitting History and Physical documented the patient suffered an intraoperative fracture of the trochanter (the bony prominence at the top of the femur near the hip). The admitting physician documented this fracture complicated rehabilitation in that the patient was restricted to toe touch weight bearing precautions, in addition to routine hip precautions instituted after hip surgeries. The physician indicated the patient required acute inpatient rehabilitation for a number of reasons, including the need for an intense level of physical and occupational therapy.

The surgeon's admission orders for the patient's therapy included physical and occupational therapy to evaluate and treat, toe touch weight bearing on the left lower extremity, and a follow up visit in ten days.

Physical therapy notes revealed that the patient received physical therapy twice a day, one session was approximately 60 minutes and another session was 30 minutes. There was documentation that the patient had difficulty with the weight bearing precautions for the left hip. Improvement with adhering to this precaution was noted throughout the course of treatment.

Documentation from four therapy sessions revealed the patient complained of pain. However it was documented the pain was tolerable and medication (or other intervention) was provided to the patient. Review of physician progress notes and nursing documentation indicated pain was addressed and managed in an appropriate manner.

The Physical Therapy Site Manager was interviewed. He stated he reviewed the medical record and confirmed the therapy sessions did not indicate anything unusual in regards to the length or regimen of the sessions.

The Director of Rehab Services was interviewed. She stated she reviewed the medical record and interviewed staff members who cared for the patient. She stated she specifically reviewed the medical record in an attempt to correlate a significant increase in pain during a therapy session (which may have indicated a worsening injury). She stated she was unable to find such a correlation and stated the medical record indicated the patient received appropriate pain management interventions with

positive results.

The Director of Rehab Services also stated that the hospital was continuing their effort to contact the patient's surgeon regarding this issue in an effort to determine if the surgeon would like to change the orders/protocol for his patients.

During the survey, four medical records of patients who had been discharged and six current medical records were reviewed. Three of these medical records (two closed and one current) were for patients treated by the same physical therapy assistant as the record above. Medical record review revealed a similarly intense therapy regimens as described above.

Five current patients were interviewed, including one who was treated by the same physical therapy assistant. All patients stated they were satisfied with the care they received and the regard with which they were treated.

It could not be verified that a patient's injury had worsened as a result of treatment at the hospital.

Conclusions: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

AIMEE HASTRITER Health Facility Surveyor

Non-Long Term Care

SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

AH/srp